Assistive Technology Client Profile Form

Client Name _____ Date _____

Telephone Number _____

Address _____ Age _____

_____ County _____

Disability _____

Are you receiving any other type of assistance, such as fuel, Medicaid, food stamps, etc.?

___ No ___ Yes If yes, what type: _____

Person & affiliation completing form: _____

Telephone: _____ E-mail address: _____

1. | Yes | No | **Do you need assistance caring for yourself in the following areas?**
If yes, please check areas of difficulty:

___ Put away groceries
___ Prepare meals
___ Feed yourself
___ Clean house
___ Manage trash / recycling
___ Yard work / gardening
___ Laundry
___ Grooming: hair / makeup / teeth
___ Dressing: ties / buttons / snaps / zippers
___ Take medications
___ Collect / send mail
___ Handle finances / money
___ Sense hot / cold temperatures
___ Home leisure
    ___ Pet care
    ___ Houseplants
    ___ Crafts
    ___ Reading

Please list AT you are currently using to assist with above tasks:

_____

Notes _____

_____

_____

2. | Yes | No | **Do you have concerns feeling comfortable and safe where you live or will live?**

If no, please check areas of difficulty:

___ Feel safe from danger, risk, or injury
___ Call for help – use a telephone
___ Professional support
___ Personal support, such as friends, relatives, and neighbors

Please list AT you are currently using to assist with above tasks:

_____

Notes _____

_____

_____

3. | Yes | No | **Do you feel comfortable and safe in the bathroom?**

If no, please check the areas of difficulty:

___ Getting in and out of shower / bathtub
___ Getting on / off the toilet
___ Regulating water temperature
___ Turning the tap on / off
___ Slippery surfaces
___ Bathtub / sink overflowing

Please list AT you are currently using to assist with above tasks:

_____

Notes _____

_____

_____

4. | Yes | No | **Do you have trouble moving from one place to another?**

If yes, please check the areas of difficulty:

___ Get up from floor
___ Sit down / get up from a chair
___ Sit with stability
___ Get into / out of a car or other transportation
___ Drive your own vehicle

Please list AT you are currently using to assist with above tasks:

_____

Notes _____

_____

_____

5. | Yes | No | **Do you have trouble with mobility / getting around?**

If yes, please check areas of difficulty:

Areas of difficulty
___ Entering / exiting house
___ Flat surface
___ Balance
___ Climb stairs
___ Descend stairs
___ Move backwards
___ Negotiate a path through house and obstacles
___ Thresholds (doorways) / opening heavy doors
___ Ramps or inclines
___ Slippery surfaces

AT used
___ Manual wheelchair
  ___ Self propel using your arms / hands
  ___ Self propel using your legs / feet
___ Power wheelchair
___ Power scooter
___ Cane
___ Walker

Please list other AT you are currently using:

_____

Notes _____

_____

_____

6. | Yes | No | **Do you have trouble using your arms / hands / fingers?**

If yes, please check areas of difficulty:

___ Push / pull / carry a 5 pound load (a bag of sugar or potatoes)
___ Lift an object over your head
___ Stabilize an object with one hand and act on it with the other (jar)
___ Push / pull / slide objects placed on a counter, table, or shelf
___ Rotate your forearms as if to open a doorknob
___ Steady arm / hand movements
___ Fine work such as keyboarding, writing, or handicrafts
___ Grasp / squeeze and manipulate objects – toothpaste – scissors – doorknobs/handles
___ Pinch with power and precision (tie shoes or put on jewelry)

Please list AT you are currently using to assist with above tasks:

_____

Notes _____

_____

_____

7. | Yes | No | **Do you have trouble communicating with others?**

If yes, please check areas of difficulty:

Methods of communication:
___ Speech
___ Writing
___ Telephone
___ Reading
___ Other _____

Areas of difficulty:
___ Understand what others are communicating to you
___ Get others to understand you when you communicate with them
___ Following or giving directions

Please list AT you are currently using to assist with above tasks:

_____

Notes _____

_____

_____

8. | Yes | No | **Do you have trouble hearing things?**

If yes, please check areas of difficulty:

Areas of difficulty:

___ Speech / voices on the telephone / TV / music / radio
___ Sounds such as a beep / alarm clock
___ High frequency sounds such as a telephone or a door chime

AT used:

___ Hearing aids
___ Other amplification _____

Please list other AT you are currently using:

_____

Notes _____

_____

_____

9. | Yes | No | **Do you have difficulty smelling / tasting things?**

If yes, please check areas of difficulty:

___ Smell / taste food that has spoiled
___ Smell gas / smoke

Please list AT you are currently using to assist with above tasks:

_____

Notes _____

_____

_____

10. | Yes | No | **Do you have trouble seeing things?**

If yes, please check areas of difficulty:

Areas of difficulty:

___ Scan your environment
___ Perceive depth, distance, and edges
___ At distances beyond reading distances
___ See in dim, reduced, or changing lights

AT used:

___ Glasses / contact lenses
___ Other visual aids _____

Please list other AT you are currently using:

_____

Notes _____

_____

_____

11. | Yes | No | **Do you have thinking issues that are interfering with your independence?**

If yes, please check areas of difficulty:

___ Memory
___ Planning
___ Problem solving

Please list AT you are currently using to assist with above tasks:

_____

Notes _____

_____

_____

What issues would you like to address first? _____

_____

_____

To Be Completed By IPAT:

Why referred? _____

Services requested:

AT Assessment: Area _____

Funding Assistance: _____

Equipment Assistance: _____

Training Needs: _____

Referred to? _____

Date: _____

Summary: _____

_____

_____